Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Community-Based Health Initiative Request for Proposals

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Key Dates

Date(s)	Action
June 6, 2023	RFP released online
June 27, 2023	Virtual information session
June 6, 2023 – July 7, 2023	Q&A period*
September 1, 2023	Full proposal due via Submittable by 5:00 pm Eastern Time
November 6, 2023	Full proposal applicants notified of grant decisions
Early December	Grantee convening
January 1, 2024	Three-year grant term begins; 3-month planning period commences
April 1, 2024	Grant implementation and data collection begins

*Applicants may contact NIBCHI@bidmc.harvard.edu if they have questions. Questions will be posted at BIDMC.org/CHI on July 14. No questions will be accepted after July 7.

Background

Between 2020 and 2026, Beth Israel Deaconess Medical Center (BIDMC) is investing approximately $18.4 million through its Community-based Health Initiative (CHI) as part of the construction of the Klarman Building, BIDMC's new inpatient building (NIB). After a robust and transparent community engagement effort that drew upon information collected from community meetings, public comments at BIDMC Community Benefits Advisory Committee (CBAC) meetings and BIDMC's active participation in the Boston Community Health Needs Assessment (CHNA) – Community Health Improvement Plan (CHIP) Collaborative and the North Suffolk Integrated Community Health Needs Assessment (iCHNA), BIDMC's CBAC identified four priority areas for investment:

- Housing Affordability
- Jobs and Financial Security
- Behavioral Health
- Healthy Neighborhoods[1]

The priority areas intentionally align with the Boston CHNA-CHIP Collaborative's Community Health Improvement Plan. BIDMC recommends applicants review the Boston CHNA-CHIP Collaborative's 2022 Community Health Needs Assessment and Community Health Improvement Plan before submitting a response to this Request for Proposals. See **Appendix A** for additional background about the CHI. BIDMC's CBAC believes the selected health priority areas remain relevant and imperative in addressing inequities exacerbated by the COVID-19 pandemic.

[1] Please note: The Healthy Neighborhoods priority area was funded through a separate process not included in this Request for Proposals.

RFP Core Principles

The core principles guiding this Community-based Health Initiative RFP are:

IMPACT: Support evidence-based and evidence-informed strategies and programs that positively and meaningfully impact neighborhoods and populations in Boston that face the greatest health inequities.

COMMUNITY: Build community cohesion and capacity by actively engaging with community residents and other stakeholders, including historically underserved or underrepresented populations.

HEALTH AND RACIAL EQUITY: Use a health and racial equity lens to dismantle systems of oppression and work towards the systemic, fair and just treatment of people of all races, ethnicities, and communities so that all people are able to achieve their full health and overall potential.

SUSTAINABILITY: Encourage sustained program impact through strategies that may include: leveraging funding to continue program activities, strengthening organizational and community capacity, and forming innovative partnerships and/or cross-sector collaborations.

MOVING UPSTREAM: Address the fundamental causes, or upstream factors, of poor health and racial inequities. To learn more about the term "upstream," click here.

Previous Grantees

In 2020, after a collaborative and transparent multi-year process, BIDMC selected the first set of community organizations to receive funding for initiatives that focus on addressing upstream social determinants of health. The selected organizations began implementing evidence-based and/or evidence-informed strategies in the areas of Housing Affordability, Jobs and Financial Security, and Behavioral Health. In 2021, BIDMC launched the Healthy Neighborhoods Initiative (HNI) to fund community collectives in six priority neighborhoods in Boston: Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill, Roxbury – and the city of Chelsea.

For more information about these grantees, visit the funded organizations page.

Request for Proposals (RFP) Overview

BIDMC is launching this second and final Community-based Health Initiative Request for Proposals (RFP) to fund the implementation of evidence-based and/or evidence-informed strategies in the areas of Housing Affordability, Jobs and Financial Security and Behavioral Health. This RFP focuses on addressing upstream social determinants of health by funding programs and initiatives that lead to more equitable and healthy communities. BIDMC recognizes the need for intentional policy and systems change aimed at increasing health and racial equity and will apply this lens when evaluating proposals.

This RFP will award up to $7.25 million over three years to organizations that will implement evidence-based and/or evidence-informed strategies. Applicants will apply for funding based on their selected priority area. See Table 1 for more details. BIDMC recognizes that an applicant's project may address multiple priority areas. For the purpose of this application, please identify the priority that most closely aligns with your project.

Table 1: Funding Amounts

Priority Area	Max. Funding amount per grantee (disbursed over 3 years)	Approx. Number of Grants To Be Awarded
Behavioral Health	$416,666	3
Jobs & Financial Security	$650,000	4
Housing Affordability	$850,000	4

Priority Area 1: Housing Affordability

The goals of the housing affordability priority area are to reduce homelessness, reduce displacement, and increase home ownership by low-income individuals and families by investing in the strategic focus areas of (i) homelessness, (ii) home ownership, and (iii) rental assistance. BIDMC aims to address the housing continuum, recognizing that people have different types of housing needs.

Affordable and stable housing is essential for anyone to realize positive health impacts and educational gains. Research shows that people experiencing housing instability often forego medical needs, experience higher rates of Emergency Department use, and are often forced to miss school and other educational opportunities.[2,3,4] Stable and affordable housing is also related to economic mobility as individuals who are evicted are more likely to lose their jobs.[5]

Research also draws links between the racial wealth gap and housing injustice.[6] Massachusetts has a long history of segregation in housing policies that have led to high levels of racial, ethnic, and economic inequities. Historic housing policies like exclusionary zoning and discriminatory mortgage lending disproportionately disadvantaged Black and Latino communities and homeowners. While there has been some effort toward integration, Boston still ranks 24th in terms of segregation among all large metropolitan areas, according to 2020 Census data.[7]

The COVID-19 pandemic has exacerbated the need for housing assistance. Data from the Boston Public Health Commission showed that 4 in 10 Boston adults reported trouble paying their rent or mortgage during the pandemic. Percentages were highest among Asian, Black and Latino Adults and adults with children in the home.[8]

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[2] Mary K. Cunningham, Robin Harwood, and Sam Hall, "Residential Instability and the McKinney-Vento Homeless Children and Education Program: What We Know, Plus Gaps in Research," Urban Institute (2010).

[3] "Housing Instability," Office of Disease Prevention and Health Promotion, last modified October 30, 2019, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/housing-instability.

[4] Margot B. Kushel et al., "Housing instability and food insecurity as barriers to health care among low-income Americans," Journal of General Internal Medicine, 21 no. 1 (2006): 71-77, doi.org/10.1111/j.1525-1497.2005.00278.x.

[5] Matthew Desmond and Carl Gershenson, "Housing and Employment Insecurity among the Working Poor," Social Problems, 63 no. 1 (February 2016): Pages 46–67, https://doi.org/10.1093/socpro/spv025.

[6] Justin Gomer, "Housing and the Racial Wealth Gap: A Historical Overview," KCET, September 4, 2018, https://www.kcet.org/shows/city-rising/housing-and-the-racial-wealth-gap-a-historical-overview.

[7] Anne Calef et al., "The Greater Boston Housing Report Card 2022 With a Special Analysis of Equity in Subsidized Housing", The Boston Foundation, October 2022, https://www.tbf.org/-/media/tbf/reports-and-covers/2022/october/gbhrc2022_interactive_web.pdf.

[8] Health of Boston Special Report: The COVID-19 Experience Among Boston Residents: Findings from the COVID-19 Health Equity Survey. Boston Public Health Commission Research and Evaluation Office, Boston, Massachusetts, 2021.

Evidence-based Strategies: Housing Affordability

Table 2 below indicates the evidence-based and/or evidence-informed strategies selected for the housing affordability priority area. Applicants are required to select strategic focus area(s) and a related strategy or strategies from this list as part of the application process.

Table 2: Housing Affordability Strategies

Strategic Focus Area	**Evidence-based or Evidence-informed Strategy**	**Description**
Homelessness	Housing First	Providing housing for the chronically homeless with appropriate levels of services.
	Supportive Services for People Experiencing Homelessness	Engaging homeless individuals with traumatic experiences in a manner that recognizes the presence of symptoms of trauma and leads to healing centered practices.
	Drive Public Policies to Prevent or Reduce Homelessness	Providing support to coalitions driving city and state-wide policies that prevent homelessness and/or promote housing stability.
Home Ownership	Down Payment Assistance and Home Ownership Education	Providing low-income first-time homebuyers with down payment assistance in the form of loans or capital and education about buying a first home.
	Zero and/or Low Interest Home Loans	Supporting Housing Trust and/or Equity Funds that assist racially and ethnically diverse low-income homebuyers and non-profit housing developers.
	Foreclosure Prevention	Providing low-income homeowners with assistance to prevent foreclosures in neighborhoods affected by gentrification and displacement.
Rental Assistance	Flexible Financial Assistance	Providing funds to individuals to assist in maintaining housing stability and/or to attain stable affordable housing (e.g., first and last month's rent).
	Eviction Prevention	Intervening in eviction processes and supporting renters by increasing access to legal services and eviction prevention programs.

Priority Area 2: Jobs and Financial Security

The goals of the jobs and financial security priority area are to increase employment and earnings and increase financial security by focusing on (i) education and workforce development, (ii) creating employment opportunities, and (iii) income/financial supports aimed at enhancing economic security and wealth accumulation.

Jobs and financial security are closely tied to stable housing, overall health and the ability to afford and access health care. Being in poor health is associated with increased risk of job loss, and there is strong evidence of an association between unemployment and poorer health outcomes. Examples of negative health outcomes associated with unemployment include increases in depression, anxiety, mixed symptoms of distress, and low self-esteem.[9]

[9] Larisa Antonisse and Rachel Garfield, "The Relationship Between Work and Health: Findings from a Literature Review," August 7, 2018, https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

Wealth also plays a role in enabling families to manage current financial challenges and make investments in their future. Families that have accumulated some wealth are better equipped to manage unanticipated expenses like an emergency medical bill or disruptions in household income without accumulating debt, exhausting assets and becoming impoverished. Over the longer term, wealth can improve the prospects of the next generation, helping to pay for college, providing a down payment for a home, or starting a new business.[10] The COVID-19 pandemic has led to large increases in unemployment and loss of financial security. Approximately 43.7% of Boston adults reported loss of income during the pandemic. This was higher for individuals who identified as Black or Latino.[11]

Evidence-based Strategies: Jobs and Financial Security

Table 3 below indicates the evidence-based and/or evidence-informed strategies selected for the jobs and financial security priority area. Applicants are required to select strategic focus area(s) and a related strategy or strategies from this list as part of the application process.

Table 3: Jobs and Financial Security Strategies

Strategic Focus Area	Evidence-based or Evidence-informed Strategy	Description
Education/Workforce Development	Adult Vocational Training	Programs that support acquisition of job-specific and soft skills/job readiness skills through education and certification programs.
	Sector-based Workforce Initiatives	Industry-focused education and job training based on the needs of regional employers within specific industry sectors.
	Youth Employment Programs	Providing short-term or long-term jobs for youth, usually 14-24 years old (e.g., summer or yearlong youth employment programs).
	Labor/Workforce Exchange	Providing career guidance and navigation support to individuals who would like to or need to switch careers (e.g., one-stop career centers).
Employment Opportunities	Transitional Jobs Programs	Time-limited, subsidized, paid jobs intended to provide a bridge to unsubsidized employment.
	Providing Flexible Access to Capital for Small Businesses	Providing low-interest loans or small grants to minority and women-owned small businesses to create new job opportunities.
Income/Financial Supports	Enhancing Economic Security and Wealth Accumulation	Providing resources and support to individuals aimed at increasing economic security and wealth accumulation (e.g., financial coaching, savings vehicles, etc.).

[10] Amy Traub et al., "The Asset Value of Whiteness: Understanding the Racial Wealth Gap," 2017, https://heller.brandeis.edu/iasp/pdfs/racial-wealth-equity/racial-wealth-gap/asset-value-whiteness.pdf.

[11] Boston Public Health Commission Research and Evaluation Office, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021

Priority Area 3: Behavioral Health

The goal of the behavioral health priority area is to increase access to high-quality and culturally and linguistically appropriate mental health and substance use services by (i) building provider and community capacity to provide trauma-informed and culturally and linguistically appropriate behavioral health care and (ii) reducing stigma surrounding mental health and substance use.

Individuals with behavioral health problems face several barriers that impact their quality of life. Mental health disorders are linked to poor social, cultural, and economic outcomes.[12] Individuals who are facing behavioral health problems can have about 5% higher workplace absence rates than someone who does not have a mental health illness. Additionally, individuals who struggle with behavioral health are six times as likely to have decreased productivity compared to their colleagues who do not have behavioral health problems.[13] Absenteeism and decreased productivity may lead to job loss, negatively impacting employment and their ability to earn a living. In turn, individuals who face behavioral health problems are at higher risk of becoming homeless. A study published by the US Department of Housing and Urban Development found that about 45% of homeless individuals suffer from some form of mental illness, with 25% of people being severally mentally ill.[14] Poor behavioral health can influence various aspects of an individual's life, decreasing their overall quality of life.

The COVID-19 pandemic has likely contributed to greater needs in the area of behavioral health due to job loss, food insecurity, housing instability, and other factors. In 2020, the Massachusetts Department of Public Health COVID-19 Community Impact Survey found that 35.4% of respondents from Boston reported having poor mental health for at least 15 out of the 30 days. COVID-19 has also led to high rates of job loss, which is associated with increased depression, anxiety, distress, and low self-esteem; and may lead to higher rates of substance use disorder.[15] Furthermore, the COVID-19 pandemic highlights existing barriers to mental health treatment for people of color, such as lower access to needed treatment, premature termination of treatment, and less culturally responsive care.[16]

Evidence-based Strategies: Behavioral Health

Table 4 indicates the evidence-based and/or evidence-informed strategies selected for this RFP in the priority area of behavioral health. Applicants are required to select strategic focus area(s) and a related strategy or strategies from this list as part of the application process.

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[12] "Mental Health Action Plan 2013-2020," World Health Organization, 2013, https://apps.who.int/iris/bitstream/handle/10665/89966/9789241506021_eng.pdf;jsessionid=A487281A01A09423E619A730F8F55830?sequence=1.

[13] Melisa Bubonya, Deborah A. Cobb-Clark, Mark Wooden, "Mental Health and Productivity at Work: Does What You Do Matter," Labour Economics 46 (June 2017): 150-165, https://doi.org/10.1016/j.labeco.2017.05.001.

[14] Peter Tarr, Ph.D., "Homelessness and Mental Illness: A Challenge to Our Society," Brain and Behavior Research Foundation, November 19, 2018, https://www.bbrfoundation.org/blog/homelessness-and-mental-illness-challenge-our-society.

[15] Massachusetts Department of Public Health COVID-19 Community Impact Survey, 2021. https://www.mass.gov/resource/covid-19-community-impact-survey

[16] SAMHSA. Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S. https://www.samhsa.gov/sites/default/files/covid19-behavioral-health-disparities-black-latino-communities.pdf

Table 4: Behavioral Health Strategies

Strategic Focus Area	**Evidence-based or Evidence-informed Strategy**	**Description**
Mental Health and Substance Use	Building Provider Capacity	Initiatives that increase and strengthen the workforce for behavioral health care. Strategies for building behavioral health provider capacity include: 1. *Supporting providers in utilizing Medication-Assisted Treatment (MAT)*, which is the combination of medication and behavioral therapy to reduce substance use; 2. *Telehealth* which involves leveraging technology to interact with medical professionals; and 3. *Primary care integration*, which involves screening patients for behavioral health problems and referring them to a behavioral health provider who is co-located (or vice versa, a behavioral health provider referring to a primary care provider who is co-located).
Mental Health and Substance Use	Building Community Capacity to Provide Behavioral Health Services	Initiatives that increase and strengthen the community's capacity to bring behavioral health interventions into the community as a supplement to clinical programming. BIDMC has identified five innovative and evidence-based strategies for building community capacity to provide behavioral health services: 1. *Community health workers* who have extensive knowledge on a community to connect individuals with behavioral health problems to care and resources; 2. *School-based mental health centers* which bring behavioral health services to schools; 3. *Mental Health First Aid*, a program that increases community members' knowledge on behavioral health issues and how to address them in a crisis; 4. *Peer-to-peer programs* which connect individuals with mentors from a similar background who previously faced a behavioral health problem; and 5. *Community-based interventions* that bring behavioral health conversations and care into community settings that people frequent (e.g., barbershops, faith-based organizations, libraries, etc.).
Mental Health and Substance Use	Increasing Education on Behavioral Health to Reduce Stigma	Increasing the communities' knowledge about behavioral health to reduce stigma and increase utilization of appropriate behavioral health care. BIDMC has identified two innovative and evidence-based strategies to increase education on behavioral health to reduce stigma: 1. *Education and Community Dialogue on Behavioral Health to Reduce Stigma*; and 2. *Increasing education to reduce stigma* related to use of Medication-Assisted Treatment (MAT).

Focus Populations

The focus populations for this RFP, determined based on BIDMC's most recent Community Health Needs Assessment and discussions with the CBAC, are:

- Youth
- Older adults
- Low-resourced populations
- Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex and Asexual (LGBTQIA+) individuals
- Racially, ethnically, and linguistically diverse population
- Families and individuals affected by violence and/or incarceration

Eligibility

To be eligible to apply for this RFP, organizations must be tax-exempt (organization with 501(c)3 status) or a public agency. Eligible institutions may include community-based organizations, community health centers, schools, coalitions, and city agencies. In addition, organizations must currently serve individuals connected to the following neighborhoods in Boston that have been specifically identified as high priority neighborhoods for this RFP:

- Allston/Brighton
- Bowdoin/Geneva
- Chinatown
- Fenway/Kenmore
- Mission Hill
- Roxbury

Lead organizations must have a strong history of working in one or more of the neighborhoods listed above. Funds may only be used to serve individuals and families that live, work, play, study, and/or receive services in the priority neighborhoods above.

Lead organizations may submit a maximum of one application for this RFP.

Evaluation

BIDMC is working with an external evaluator, Health Resources in Action (HRiA). HRiA is conducting an overarching evaluation of the BIDMC CHI. The purpose of the overarching BIDMC CHI Evaluation is to learn across the BIDMC CHI:

- To what extent have the priority populations been reached?
- To what extent have outcomes improved across the participant population and/or what progress has been made towards policy change? E.g., How will we know we are successful?

All grantees will be required to develop and implement an individual evaluation plan, participate in the overarching evaluation (led by HRiA) and report on program-specific evaluation measures to BIDMC. HRiA will provide support and technical assistance, as described below.

Overview of Evaluation Expectations

All grantees will work closely with HRiA. HRiA will:

- Conduct an overarching evaluation of the entire initiative to demonstrate collective impact of funds.
- Facilitate the development of shared measures for the overarching evaluation.
- Collaborate with each grantee to support the development of their individual evaluation plan and ensure alignment with the overarching evaluation. This individual evaluation plan will include required elements for the overarching evaluation conducted by HRiA and program-specific evaluation elements that grantees will report to BIDMC (see below).
- Provide technical assistance to grantees implementing their individual evaluation plans.
- Clean, analyze, and report on overarching evaluation measures.
- Facilitate evaluation webinars.

During a three-month planning process (January-March 2024), grantees will:

- Collaborate with HRiA to update/revise their logic model and develop an individual evaluation plan that aligns with the overarching evaluation.
- Participate in monthly webinars and monthly technical assistance calls and be in regular communication with HRiA.
- Come to consensus with other grantees and HRiA on a set of at least 1-3 shared outcome measures in their funded priority area.
- Develop and/or adapt data collection tools and processes to gather data on required sociodemographic measures (see **Appendix E**) and agreed-upon shared outcome measures for the overarching evaluation.
- Update the Data Use Agreement (DUA) to include the agreed upon implementation and shared outcome measures for the overarching evaluation. (See **Appendix G** for the draft DUA that will be executed with funded grantees' agreements. An addendum will be added by the end of the planning period to include agreed upon shared process and outcome measures.)
- **NOTE:** Program implementation and data collection cannot begin prior to the conclusion of the overarching evaluation planning process (March 2024).

During grant implementation (April 2024 – December 2026), for the **overarching evaluation**, grantees will:

- Begin program implementation and data collection in April 2024. Data collection should continue for the duration of program implementation through and including December 2026. For the overarching evaluation, only data collected through September 30, 2026 will be included.
- Participate in quarterly technical assistance calls with HRiA.
- For grantees reaching individual participants, collect individual level data that is tracked with unique identifiers to enable the matching/linking of baseline data to follow-up data. For each program participant:
    - Collect data on a defined set of **sociodemographic measures** to determine project reach (including neighborhood affiliation, race, ethnicity, primary language, gender identity, sexual orientation, age, history of incarceration, household/family income and size, etc.) (See **Appendix E** for a full list of sociodemographic measures).
    - Track **service delivery** at the individual participant level (participant enrollment, participants lost to follow up, services delivered, services received).

- Collect **outcome data** on a set of shared evaluation measures, specific to the grantee's funded priority area. To measure impact, or change over time, data will need to be collected at a minimum of two timepoints (baseline and endpoint/follow-up). These measures will collectively answer the evaluation question '*how will we know we are successful?*' These measures will be established by the cohort of grantees during the planning phase (January-March 2024) as described above. Shared outcome measures will be collected using validated tools where possible; examples include:
  - Housing Affordability: Housing instability scale; Housing situation (description and satisfaction); Housing agency; Housing affordability
  - Behavioral Health: PHQ-9, RAS-DS Scale, GHSQ Scale
  - Jobs & Financial Security: Financial Capability Scale; Hope Scale

  (See **Appendix F** for more information on example evaluation questions and corresponding measures and tools.)
- Share with HRiA a codebook, data dictionary, or instrument with the full list of response options.

- For grantees working on policy or systems change initiatives:
  - Work with HRiA to determine, define and collect appropriate **process and outcome measures**, as well as frequency of data collection. For example, this may include data collection on policy and community organizing / advocacy activities.
- For all grantees:
  - Collect grant **implementation measures** (i.e., staff hired, including positions of staff hired; staff trained, including topics of training; individuals reached, if different than evaluation participant enrollment).
  - On a quarterly basis, submit cumulative data collected to date. All individual level data will be de-identified.
  - Participate in staff interviews conducted by HRiA in the final year of grant implementation.
  - Participate in one evaluation webinar.

During grant implementation (April 2024 – December 2026), for the grantees' **individual program-specific** evaluation, grantees will:

- Collect aggregate program-specific measures, outside of the shared overarching measures, and report on these measures to BIDMC quarterly along with the measures for the overarching evaluation (through December 31, 2026).
- Program-specific measures may include process measures such as number of participants in program activities and outcome measures such as changes in skills, knowledge, or behaviors.

Application Components Related to Evaluation

During the information session on June 27, HRiA will review RFP evaluation requirements and be available to respond to questions. Applicants are also encouraged to review this 35-minute training video on how to develop a logic model.

A theory of change outlines the activities that will bring about change and the expected results (See here for BIDMC's visual theory of change). As part of the application, applicants will upload a logic model (using the provided worksheet, available as **Appendix D**, which includes templates for grantee programs reaching individual participants and for grantee initiatives focused on policy and systems change), that aligns with the applicant's description of their project's theory of change.

Applicants should include evaluation expenses in the proposed budget. While BIDMC has engaged an external evaluator to collaborate with grantees on an overarching evaluation, individual grantees will be responsible for implementing an individual evaluation of their program and reporting on program-specific evaluation measures to BIDMC. Please see instructions in the Funding Guidelines and Budget section below.

Funding Guidelines and Budget

Grant funds may be used for project staff salaries, data collection and analysis, meetings, supplies, related travel, and other direct project-related expenses. Indirect expenses may not exceed 10% of the total budget. Grant funds may not be used to provide medical services, to support clinical trials, to construct or renovate facilities or capital expenses, or as a substitute for funds currently being used to support similar activities.

Evaluation Expenses

Applicants should plan to designate sufficient staff time for the evaluation activities described above, including staff time for evaluation plan development, data collection programming/setup, data collection, data entry/management, data storage, and data cleaning for the overarching evaluation.

Grantees should identify a contact for data management and tracking (the grantee evaluation contact) who will serve as the key liaison with the external evaluator. The grantee evaluation contact and project lead will participate:

a) virtually in individual, one-hour evaluation check-in meetings that occur monthly during the first three months and quarterly for the remainder of the grant period (14 sessions total across three years);
b) in monthly two-hour evaluation planning webinars during the planning phase (3 sessions total), and;
c) in one two-hour evaluation check-in webinar during the implementation phase (1 session total).

Applicants should include additional evaluation expenses in the proposed budget to accommodate on-site evaluation activities. Include costs for project evaluation activities, such as use of evaluation consultants, data collection tools, translation of data collection tools into appropriate languages, software purchases related to evaluation, and other costs for evaluation. BIDMC recommends that grantee evaluation expenses total approximately 10% of an applicant's budget).

Reporting and Convening of Grantees

Grantees will be required to report on project progress regularly through multiple avenues, such as in-person site visits, scheduled phone calls, and annual reports. BIDMC and grantees will determine shared goals, metrics, and reporting timelines that are feasible and realistic.

Grantees may also be asked to participate in up to two half-day gatherings per year and a one-day event that is open to the public to share program results.

Application Instructions and Deadline

The deadline to submit the application is September 1, 2023 by 5:00 pm Eastern Time. All applications must be submitted online through BIDMC's online platform, Submittable. The application questions are available as **Appendix B** and the scoring criteria are available as **Appendix C**.

Information Session and Contact Information

Interested applicants are encouraged to attend a virtual information session on June 27th, 2023 from 11 am – 12 pm. Responses to Frequently Asked Questions will be posted to BIDMC's website and a recording of the webinar will be posted by July 14, 2023. For additional questions, contact the BIDMC Community Benefits Team at NIBCHI@bidmc.harvard.edu. BIDMC will make every effort to respond to emails within two business days.

Appendix A: Community-based Health Initiative Background

In accordance with Commonwealth Determination of Need (DoN) requirements, in 2019 BIDMC undertook a robust community engagement effort and a facilitated prioritization process with BIDMC's Community Advisory Committee (Advisory Committee) to identify the leading community health priorities. The prioritization process was preceded by an unprecedented city-wide Community Health Needs Assessment (CHNA) overseen by the Boston CHNA – Community Health Improvement Plan (CHIP) Collaborative (the Boston Collaborative), of which BIDMC is a founding member. The Boston Collaborative conducted 13 focus groups, 45 key informant interviews, and collected 2,404 surveys from Boston residents. At the same time, BIDMC supported a robust effort in Chelsea, Revere, and Winthrop, through the North Suffolk Integrated Community Health Needs Assessment (iCHNA). The iCHNA process engaged over 2,000 North Suffolk residents.

Given BIDMC's historic focus on and commitment to the underserved, BIDMC chose to concentrate the Community-based Health Initiative (CHI) on the neighborhoods and cohorts that face the greatest health inequities with the BIDMC Community Benefits Service Area. These focus neighborhoods include the six Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Roxbury, and Mission Hill.

Augmenting the robust community engagement undertaken by the Boston Collaborative and the iCHNA, BIDMC's Advisory Committee engaged an additional 184 residents at five community meetings. Likewise, since April 2019, all BIDMC Community Benefits Advisory Committee meetings have been open to the public and welcomed oral and written comments from community members. In September 2019, the Advisory Committee determined the CHI's health priorities and the categorical allocation of funds (Table 1A below).

Table 1A**: Approved Advisory Committee Priority Areas and Funding Allocations**

Priority area	**Percent of CHI & approx. dollar amounts**	**Strategic focus area and estimated allocations**	
Housing Affordability	40% of CHI = $7.4M	Homelessness	40% = $2.9M
		Home Ownership	20% = $1.5M
		Rental Assistance	40% = $2.9M
Jobs/Financial Security	30% of CHI = $5.5M	Education/Workforce Development	85% = $4.7M
		Employment Opportunities	10% = $553K
		Income/Financial Supports	5% = $277K
Behavioral Health	15% of CHI = $2.8M	Mental Health	50% = $1.4M
		Substance Abuse	50% = $1.4M
Healthy Neighborhoods	15% of CHI = $2.8M	Access to Care	Allocation amounts for the Healthy Neighborhoods priority area sub-groups will be determined during neighborhood-specific processes. Note all Healthy Neighborhood funds have been awarded.
		Built Environment	
		Environmental Health	
		Other SDOHs	
		Violence Prevention	

Appendix B: Proposal Application Questions

1. Organizational Information

a. *Lead Organization Name*: The lead organization is responsible for ensuring that the terms of the RFP are met and, if applicable, the terms of the grant. This includes but is not limited to being the primary contact for reporting, implementation, evaluation and managing funds flow.
b. *Project Lead* (primary contact person for the application):
    i. Address, name, pronouns, email, and phone number
c. *Organization Mission and Vision*: Please describe the organization's overall mission and strategic priorities and how it aligns with the core principles in this RFP. (150 words maximum)
d. *Leadership*: Please list the members of the Board of Directors and senior leadership team.
    i. Please specifically address how your organization's leadership (Board of Directors, senior management) reflects the lived experience of the communities it serves. This may include but is not limited to: race, culture, ethnicity, disability status, religious and spiritual beliefs, gender identity, sexual orientation, and generational identity (150 words maximum).
    ii. What diversity, equity, and inclusion initiatives is the organization currently undertaking or has the organization recently undertaken to ensure organizational leadership is reflective of the communities served? Please specify actions taken related to racial equity, cultural humility, and language access and the results of those actions to date, including quantitative (numerical) data about the diversity of your organization's leadership. (250 words maximum)
e. *Upload the Following Documents*:
    i. Organizational budget for the current year
    ii. Most recent Internal Revenue Service Form 990
    iii. Most recent audited financial statement

2. Project Description

a. *Title*: Please provide a one-sentence title that reflects the nature of the proposed project.
b. *Priority Area:* Select which priority area this application will focus on (check one). If your project addresses more than one priority area, select the one that most closely aligns.
    a. Housing Affordability
    b. Jobs & Financial Security
    c. Behavioral Health

c. *Strategic Focus Area:* Referring to the health priority selected in question 2b., select the strategic focus area(s) according to your selected priority area.

Priority Area	Strategic Focus Area	Priority Area	Strategic Focus Area	Priority Area	Strategic Focus Area
Housing Affordability	Homelessness	Jobs and Financial Security	Education / Workforce Development	Behavioral Health	Mental Health and Substance Use
	Home Ownership		Employment Opportunities		
	Rental Assistance		Income / Financial Supports		

d. *Evidence-based / Evidence-Informed Strategies:* Select the evidence-based or evidence-informed strategies the project will use, depending on the priority area and strategic focus area(s) selected in questions 2.b and 2.c. You may select multiple evidence-based strategies.

Priority Area	Strategic Focus Area	Evidence-based / Evidence-informed Strategy
Housing Affordability	Homelessness	• Housing First • Supportive Services for People Experiencing Homelessness • Drive Public Policies to Prevent or Reduce Homelessness and/or promote housing stability
	Home Ownership	• Down Payment Assistance and Home Ownership Education • Zero and/or Low Interest Home Loans • Foreclosure Prevention
	Rental Assistance	• Flexible Financial Assistance • Eviction Prevention
Jobs and Financial Security	Education / Workforce Development	• Adult Vocational Training • Sector-based Workforce Initiatives • Youth Employment Programs • Labor/Workforce Exchange
	Employment Opportunities	• Transitional Jobs Programs • Providing Flexible Access to Capital for Small Businesses
	Income / Financial Supports	• Enhancing Economic Security and Wealth Accumulation (e.g., financial coaching, savings vehicles, etc.)
Behavioral Health	Mental Health and Substance Use	• Building Provider Capacity • Building Community Capacity to Provide Behavioral Health Services • Increasing Education on Behavioral Health to Reduce Stigma **Note**: See strategy descriptions in Table 4 for examples of programs in each of these categories.

e. *Project Overview:* Please provide a brief description of the project(s) the organization is seeking to fund (300 words maximum).
    i) *Project Context*:
        i. Will funds be used to create a new program, expand existing work, or both?
            1. If funds will expand existing work, please explain how the reach of your program will increase because of this funding (50 words maximum).
        ii. Describe the need the organization is addressing. (100 words maximum)
            1. Explain how the project is upstream or moves upstream (i.e. addresses root causes of the community need(s))

f. *Populations Served***:** Describe the specific population(s) the project will focus on and briefly describe examples of the work the organization has done serving the selected populations, including any current partnerships with organizations serving those population(s). Refer to page 9 for BIDMC's priority populations. (100 words maximum)
    i. Describe how the project will address key challenges facing these populations. (100 words maximum)

g. *Neighborhoods Served:* Identify the neighborhood(s) the project will serve (check all that apply):
    b. Allston/Brighton
    c. Bowdoin/Geneva
    d. Chinatown
    e. Fenway/Kenmore
    f. Mission Hill
    g. Roxbury
        i. Please briefly describe examples of the work the organization has done in the selected neighborhoods, including any current partnerships with organizations located in the neighborhood(s) and your plan for engaging populations connected to those neighborhood(s) (150 words maximum)

h. *Project Goals*: Provide up to three SMART (specific, measurable, attainable, relevant, and timely) goals per health priority/strategic focus area that align with the outcomes in BIDMC's theory of change **.** All goals should have a racial equity focus/lens. Note that additional metrics will be determined and required in collaboration with the external evaluation team.
    i. What will the impact of this work be at the end of this funding (i.e., after 3 years)?
    ii. What are markers for success along the way (e.g., after one year)?
    iii. How will you know if you are successful? How will you measure success?

i. *Project Logic Model:* Upload the Logic Model worksheet (see **Appendix D**) and provide a brief description of the theory of change for the project (i.e., a statement of the activities that will bring about change and the results your project will achieve for the participants and the community) (See **here** for reference).

j. *Anticipated Reach*: Please provide an expected range for the number of individuals the organization will reach or impact through the project beyond the number currently served. Please explain how you reached the numbers provided and what assumptions underlie them.

k. *Project Staffing:* List the key people who will be involved in project implementation and briefly describe their roles.

3. Equity and Community Engagement

a. How does the organization plan to ensure that project resources are deployed towards those that need them the most? (100 words maximum)
b. Please discuss how the organization plans to engage with the population(s) with which it will be working. Please specify the level(s) of community engagement the project utilizes based on Table 1 on page 11 in the Massachusetts Department of Public Health Community Engagement Standards for Community Health Planning. (150 words maximum)

4. Partners (if applicable)

a. List all partner organizations that are key to the success of this project. Include the sector they represent (e.g. Workforce development, behavioral health, housing, education, etc.) and a brief description of their involvement in the project. Describe how the collaboration(s) will increase the impact of the project. (250 words maximum)

5. Evaluation Capacity and Experience

This section is about your organization's/partnership's existing evaluation capacity and experience with evaluation (e.g., data collection, tracking, monitoring, reporting). You may include references to past evaluations, such as recent program evaluations.

a. Please describe how your organization/partnership collects and uses data (300 words maximum).
    i. What types of data are currently collected (if any)?
    ii. How does your organization collect data (if applicable)?
    iii. How does your organization use these data to inform outcomes and improve programming/ initiatives? How does your organization currently measure success?
    iv. Does your organization have experience assigning unique ID's to program participants and maintaining unique ID's across multiple timepoints? Please describe.
b. Please describe how and where your organization stores data currently. What system(s) does your organization use to store and manage data (e.g., Excel, Access, RedCAP, Salesforce), if any? (100 words maximum)
c. Please describe your organization's experience working with an external evaluator (if any) (100 words maximum).
d. Who will be the grantee evaluation contact for this project (150 words maximum)?
    i. Position title
    ii. Description of current evaluation responsibilities (if any)
    iii. Any relevant evaluation skills, knowledge, and experience (if any)

6. Budget

a. Please upload an itemized project budget and an accompanying budget narrative (up to a ½ page) using the template linked here. The budget should include direct costs and indirect costs, including staff time.

7. Sustainability

BIDMC encourages applicants to think creatively about how the funds from this request can be leveraged to create permanent community change. Please be explicit as to how metrics and outcomes will lead to sustainability beyond the grant term, aside from applying for additional funds.

a. Describe how the organization will leverage this funding to support the sustainability of the project(s). (100 words maximum)
b. How will this project contribute to improved community health beyond the initial three-year funding period? (100 words maximum)
c. Describe any challenges to sustainability the organization anticipates and how the challenges might be addressed. (150 words maximum)

Appendix C: Scoring Criteria:

Section 1: **Organizational Information** [weighted at 10% of total]

1. Clearly articulates how their mission aligns with RFP core principles
2. Organization's leadership reflects the community served on many dimensions, including culture, ethnicity, race, language, etc.
3. Organization is financially stable

Section 2: Proposed Project [weighted at 35% of total]

1. Project overview aligns with and addresses the needs and evidence-based strategies outlined in this RFP.
2. Project approach is upstream or moves upstream (i.e. addresses root causes of the community need(s))
3. Clear, measurable, and attainable goals
4. Clearly articulated project logic model
5. Demonstrated organizational capacity (e.g., adequate staffing) to carry out the project
6. Clearly defined population to be served, centering on the focus populations for this RFP
7. Strong history of working in one or more RFP focus neighborhoods
8. (If applicable) Proposed partnership(s) can increase the impact of the program

Section 3: Community Engagement and Equity [weighted at 25% of total]

1. Project would meaningfully address health and racial inequities in the community
2. Clear outreach plan for reaching population(s) disproportionately impacted by racial/ethnic and socioeconomic health inequities
3. High level of community member involvement/engagement in the proposed project based on the MA DPH Community Engagement Continuum (pages 7 and 11)

Section 4: Evaluation, Budget, and Sustainability [weighted at 30% of total]

1. Organization has capacity to conduct evaluation activities and/or previous experience with evaluation
2. Budget is reasonable to complete the proposed activities
3. Clear plans to leverage funding received to support the sustainability of the project(s)
4. Project will lead to sustained improvements in community health outcomes
5. Clear articulation of anticipated challenges to sustainability and how they might be addressed

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Appendix D: Logic Model Worksheets

Logic Model Worksheet – for grantee programs reaching individual participants

Name of program: _____

Instructions: Please list all project goals, as stated in your application, and the activities your organization will conduct as part of the project to achieve these goals. Then complete the columns to the right with the expected output (changes) and outcomes (results) of the activities.
Priority Area: _____ **Strategic Focus Area(s):** _____

Target Population (*Who will benefit)*: _____

Goal 1: _____

Goal 2: _____

Goal 3: _____

Inputs *What resources do you need?*	**Activities** *What services does the program offer? What will you do?*	**Outputs** *How will you know you completed this activity? What are the direct products of the activities?*	**Short-term Outcomes** *What will you accomplish in the short-term (weeks/months) as a result of this activity?*	**Intermediate Outcomes** *What will happen in the medium-term (within the life of this grant) as a result of this activity?*	**Long-term Outcomes** *What do you anticipate the long-term impacts (beyond the time of this grant) will be?*

Logic Model Worksheet – *for grantee initiatives focused on policy and systems change*

Name of initiative: _____

Instructions: Please list all project goals, as stated in your application, and the activities your organization will conduct as part of the project to achieve these goals. Then complete the columns to the right with the expected output (changes) and outcomes (results) of the activities.

Priority Area: _____ **Strategic Focus Area(s):** _____

Target Population (*Who will benefit? What populations will be impacted by policy or systems change?)*: _____

Goal 1: _____

Goal 2: _____

Goal 3: _____

Inputs *What resources do you need?*	**Activities** *What will you do?*	**Outputs** *How will you know you completed this activity?*	**Short-term Outcomes** *What will you accomplish in the short-term (weeks/months) as a result of this activity?*	**Intermediate Outcomes** *What will happen in the medium-term (within the life of this grant) as a result of this activity?*	**Long-term Outcomes** *What do you anticipate the long-term impacts (beyond the time of this grant) will be?*

Appendix E. Shared Sociodemographic Measures

SOCIODEMOGRAPHIC DATA:

Required Measures. Our aim is that a core set of sociodemographic measures is collected in a consistent format by all grantees with flexibility in how these measures are captured (e.g., categories used). In the table below are the required formats and suggested categories. The HRiA team will work with you to ensure that these data can be collected in a realistic and feasible way that minimizes grantee and participant burden.

Required Sociodemographic Measures	**Recommended Question**	**Required Format**	**Suggested Categories** (if applicable) *Note: These are examples of categories. If grantees currently capture a proposed sociodemographic measure they can discuss using their existing categories with HRiA or use revised categories.*
BIDMC Priority Neighborhoods: Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Roxbury, and Mission Hill			
Priority Neighborhood Affiliation (to be reviewed and refined as needed with grantees during Planning Phase)	Which of the following Boston neighborhoods are you connected to?		
	a. What is the zip code where you live?	Open numeric field	Not applicable
	b. What is the zip code where you work?	Open numeric field	Not applicable
	c. What other Boston neighborhoods are you connected do? For example, do you receive services, visit family or friends, go to school or places of worship, in any of the following neighborhoods?	Categories (select all the apply)	**REQUIRED CATEGORIES:** Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Roxbury, Mission Hill, None of the above
BIDMC Priority Population: Racially, ethnically and linguistically diverse communities			
Race	How do you describe your race? Please note that for this question Hispanic origins are not considered a race.	Categories (select all the apply)	Recommend US census categories or similar (e.g., White, Black or African American, Asian, Native Hawaiian or Other Pacific Islander, American Indian or Alaska Native, Other, None of the above)
Ethnicity	What is your ethnicity?	Categories (select all that apply)	Example list of categories can be tailored to population served:

Required Sociodemographic Measures	**Recommended Question**	**Required Format**	**Suggested Categories** (if applicable) *Note: These are examples of categories. If grantees currently capture a proposed sociodemographic measure they can discuss using their existing categories with HRiA or use revised categories.*
			European: German, Italian, Irish, Polish, English, French, Other **Black or African American:** African American, Barbadian, Cape Verdean, Ethiopian, Haitian, Jamaican, Nigerian, Somali, Other **Middle Eastern or North African:** Lebanese, Syrian, Iranian, Moroccan, Egyptian, Israeli, Other **Hispanic, Latino, or Spanish:** Mexican or Mexican American, Salvadoran, Puerto Rican, Dominican, Cuban, Colombian, Guatemalan, Honduran, Other **Asian:** Asian Indian, Cambodian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other **Native Hawaiian or Other Pacific Islander or American Indian/Alaskan Native:** Native Hawaiian, Tongan, Samoan, Fijian, Chamorro, Marshallese, American Indian or Alaska Native, Other
Primary language	What is the primary language you speak at home?	Categories (select one)	English, Spanish, Portuguese, Cape Verdean Creole, Haitian, Chinese (including Mandarin and Cantonese), Vietnamese, Korean, Cambodian/Khmer, French (including Cajun), Arabic, Russian, Other (please specify)
Non-/U.S. born OR Length of time in U.S.**	Were you born in the United States? OR	Categories or open numeric field	Yes, No Less than 1 year, 1-5 years, 6-10 years, More than 10 years, My whole life (I was born in the United States)

Required Sociodemographic Measures	**Recommended Question**	**Required Format**	**Suggested Categories** (if applicable) *Note: These are examples of categories. If grantees currently capture a proposed sociodemographic measure they can discuss using their existing categories with HRiA or use revised categories.*
	How long have you lived in the United States?		
BIDMC Priority Population: Lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA+) population**			
Gender Identity**	How do you describe your gender identity?	Categories (select all that apply)	Male, Female, Transgender male, Transgender female, Genderqueer (neither exclusively male or female), Additional gender category (please specify)
Sexual Orientation**	How do you describe your sexual orientation?	Categories (select all that apply)	Straight (heterosexual), Lesbian, Gay, Bisexual, Asexual, Not Sure/Questioning, Other (please specify)
BIDMC Priority Population: Youth, older adults			
Age	What is your birthdate? OR How old are you, in years?	Open numeric field; if providing age in years, must be submitted as a continuous variable	Date of birth OR Age in years
BIDMC Priority Population: Individuals or Families Affected by Incarceration and/or Violence**			
History of Incarceration**	Have you been arrested before (spent time in Jail/Prison)?	Categories	Yes/No
BIDMC Priority Population: Low resource families **(Capture at least one of the following measures for all participants)**			
Preferred: Current household/family income AND size	What was your household's total income for the past 12 months? This should include all income, including: wages, salary, commissions, bonuses, tips, self-employment income, interest, dividends, net rental income, social security, SSI, any	Open numeric field	Not applicable

Required Sociodemographic Measures	**Recommended Question**	**Required Format**	**Suggested Categories** (if applicable) *Note: These are examples of categories. If grantees currently capture a proposed sociodemographic measure they can discuss using their existing categories with HRiA or use revised categories.*
	public assistance such as welfare payments, retirement income, pensions, survivor or disability income, and other regular sources of income (e.g., unemployment, VA payments, child support, alimony). **AND** How many people live in your household?		
Alternative: Education level (NOTE: If program predominantly serves individuals under 25, this measure is not applicable and should not be selected)	What is the highest degree or level of school you completed?	Categories (select one)	U.S. Census categories or similar: No schooling completed; Less than high school degree; Regular high school diploma, GED or alternative credential; Some college credit, no degree; Associates degree (for example: AA, AS); Bachelor's degree (for example: BA, BS); Advanced degree beyond bachelor's degree
Alternative: Current Employment status	Which of the following best describes your employment in the last week?	Categories (select one)	Employed for wages part-time, Employed for wages full-time, Self-employed, Out of work for 1 year or more, Out of work for less than 1 year, A homemaker, A student, Retired, Unable to work
Alternative: Current Enrollment in benefits programs	Which of the following benefit programs are you, or your household, currently enrolled in?	Categories (select all that apply)	AFDC (Aid to Families with Dependent Children), Free/Reduced Lunch, Medicaid, Refugee Assistance, TAFDC (Transitional Aid to Families with

Required Sociodemographic Measures	**Recommended Question**	**Required Format**	**Suggested Categories** (if applicable) *Note: These are examples of categories. If grantees currently capture a proposed sociodemographic measure they can discuss using their existing categories with HRiA or use revised categories.*
			Dependent Children), WIC, Food Stamp (SNAP), MassHealth Insurance, Public Housing, RAFT, ERMA, HomeBase, SSI/SSDI, Unemployment, Other (please specify)

** The HRiA team will work with you if have any concerns about these measures given your specific participant population.

Appendix F: Example Evaluation Questions and Measures

Shared outcome measures for the overarching evaluation will be established by the cohort of grantees during the planning phase. Specific evaluation questions, measures, and tools selected will be dependent on the cohort of grantees that are funded and the specific focus of their projects and initiatives. Example evaluation questions, outcome measures, and tools for individual-level participant data collection are included in the table below. NOTE: Grantees focused on policy and systems change will work with HRiA to determine appropriate measures.

Housing Affordability:

EXAMPLE Evaluation Question	**Outcome Measure**	**Evaluation Tool and Sample Questions**
Did participants' housing stability improve?	Level of Housing Instability	Housing Instability Scale[17]: 7 Question Scale: 1. In the last 6 months, have you had to live somewhere that you did not want to live? 2. Etc.
How satisfied are participants with their housing situation? Did satisfaction and/or living situation improve?	Housing Situation: Description and Satisfaction	What is your current housing situation? On a scale of 1 – 5, how satisfied are you with your current housing situation?
Did participants' agency (control and confidence) of housing situation improve / increase?	Agency	On a scale of 1 – 5, how in control do you feel of your housing situation? On a scale of 1 – 5, how confident do you feel that you will be able to improve your housing situation if needed?
Did participants' ability to afford housing increase?	Affordability	In the past 3 months, have you had to choose between paying for housing or paying for any of the following: (Response options provided; check all that apply)

[17] Farero, A., Sullivan, C.M., Lopez-Zeron, G., et al. (2022). Development and validation of the housing instability scale. *Journal of Social Distress and Homelessness.* DOI: 10.1080/10530789.2022.212785

Jobs & Financial Security:

EXAMPLE **Evaluation Question**	**Outcome Measure**	**Evaluation Tool and Sample Questions**
Did participants' financial literacy increase?	Financial Capability	Financial Capability Scale for Young Adults[18]: 6 Question scale: 1. Do you currently have a personal budget, spending plan, or financial plan? 2. Etc.
Did participants' self-efficacy increase?	Hope	The Adult Hope Scale[19]: 6-item Hope scale, with two 3-question subscales (Pathways and Agency): Using the scale (definitely false – definitely true) please select what best describes how you think about yourself right now: 1. Right now, I see myself as pretty successful. 2. Etc.

[18] Collins, J.M. & O'Rourke, C. (2013) Financial Capability Scale (FCS), University of Wisconsin Madison, Center for Financial Security. Additional information: https://fyi.extension.wisc.edu/financialcoaching/measures/

[19] Snyder, C. R., Sympson, S. C.,Ybasco, F. C., et al. (1996). Development and validation of the State Hope Scale. Journal of Personality and Social Psychology, 70, 321–335.

Behavioral Health:

EXAMPLE **Evaluation Question**	**Outcome Measure**	**Evaluation Tool and Sample Questions**
Did participants' confidence/ self-efficacy around behavioral health increase?	Confidence / Self-efficacy around behavioral health / Stigma	Recovery Assessment Scale (RAS-DS): 7 items selected adapted from the "Looking Forward" construct[20]: Please indicate how much you agree or disagree with the following statements about yourself: 1. I can handle what happens in my life 2. I like myself 3. I have an idea of who I want to become 4. Something good will eventually happen 5. I'm hopeful about my own future 6. I know when to ask for help 7. I can help myself become better
Did participants' help seeking behavior for behavioral health concerns increase?	Help seeking behavior / Stigma	Adapted from General Help-Seeking Questionnaire (GHSQ)[21]: If you were having a personal or emotional challenge, how likely is it that you would seek help from the following people? 1. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto) 2. Etc.
Did participants' mental health symptoms improve?	Mental Health Symptoms	PHQ-9: 9-Question Scale[22]: Over the last two weeks, how often have you been bothered by any of the following problems? 1. Little interest or pleasure in doing things 2. Etc.

[20] Hancock, N., Scanlan, J. N., Honey, A., et al. (2015). Recovery Assessment Scale – Domains and Stages (RAS-DS): Its feasibility and outcome measurement capacity. *Australian & New Zealand Journal of Psychiatry*. Vol. 49(7) 624–633. DOI: 10.1177/0004867414564084

[21] Wilson, C. J., Deane, F. P., Ciarrochi, J. (2005). Measuring Help-Seeking Intentions: Properties of the General Help-Seeking Questionnaire. *Canadian Journal of Counselling*. Vol. 39(1).

[22] Kroenke, K., Spitzer, R. L., Williams, J. B. W. (2001). The PHQ-9: Validity of a Brief Depression Severity Measure. *Journal of General Internal Medicine*. 16: 606-613.

Appendix G: Data Use Agreement

Beth Israel Deaconess Medical Center
New Inpatient Building
Community-based Health Initiative (CHI)
Data Use Agreement

This Data Use Agreement (Agreement), effective as of [**MONTH DAY, YEAR**] is entered into by and between Health Resources in Action, Inc. (Data Recipient) and [**GRANTEE ORGANIZATION NAME**] (Covered Entity).

WHEREAS, the purpose of this Agreement is to provide the Data Recipient with access to a Limited Data Set (LDS) from the Covered Entity for use in evaluating the Community-based Health Initiative (CHI), in accordance with contractual obligations between the Data Recipient and Beth Israel Deaconess Medical Center (BIDMC) as outlined in the Grant Agreement between the parties entered into on [**DATE]** (Grant Agreement) as well as the Agreement for Services between the Covered Entity and BIDMC effective April 1, 2019.

WHEREAS, the Covered Entity and the Data Recipient are committed to compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended and regulations promulgated thereunder; and

WHEREAS, the purpose of this Agreement is to satisfy the obligations of the Covered Entity under HIPAA and to ensure the integrity and confidentiality of certain information disclosed or made available to the Data Recipient and certain information that the Data Recipient uses, discloses, receives, transmits, maintains or creates from Covered Entity.

WHEREAS, the Covered Entity is responsible for satisfying all data-related obligations with their project-specific partners. The Covered Entity will be responsible for collecting all data for the LDS and providing it to the Data Recipient.

NOW, THEREFORE, in consideration of the foregoing recitals and other good and valuable consideration, the recipient and sufficiency of which is hereby acknowledged, the parties agree as follows:

1. **Responsibility of Covered Entity.**
    a. ***Preparation of LDS.*** Covered Entity shall prepare and furnish to the Data Recipient, a LDS in accordance with HIPAA Regulations and/or the Data Recipients standards for Minimum Necessary Data Fields in the LDS. The LDS should include the following items.
        i. Data fields specified in the Covered Entity's approved evaluation plan, which are the minimum necessary to accomplish the purposes set forth in Section 3 of this Agreement.
        ii. Raw, unadjusted, de-identified participant-level data for all evaluation participants on a quarterly basis for the life of the Covered Entity's Grant Agreement with BIDMC, including any contract extensions.
            1. All evaluation participants includes participants receiving the services who are enrolled in the evaluation.

2. If the Covered Entity is responsible for collecting comparison group data as well, this should be included as part of the LDS.

iii. Unique identification number for each participant that is not linked to the identification number used for the participant's medical records.

iv. All implementation related data on a quarterly basis for the life of the Covered Entity's Grant Agreement (including any contract extensions) with BIDMC.

v. In addition to de-identified participant-level data and implementation-related data, the Covered Entity will be required to participate in the distribution, collection and sharing of all data outlined in the Covered Entity's evaluation plan.

vi. A list of data elements is included at the end of this Agreement.

b. ***Sharing of LDS.*** Covered Entity shall electronically upload their LDS using the Data Recipient's electronic database on a quarterly basis for the life of the Covered Entity's Grant Agreement with BIDMC, including any contract extensions. A timeline for LDS sharing, based on the Covered Entity's Grant Agreement with BIDMC, is included at the end of this Agreement.

2. **Responsibilities of Data Recipient.**

a. The Data Recipient agrees to:

i. Use or disclose the LDS only as permitted by this Agreement or as required by law;

ii. Use appropriate safeguards to prevent use or disclosure of the LDS other than as permitted by this Agreement or required by law;

iii. Report any use or disclosure of the LDS of which it becomes aware that is not permitted by this Agreement or required by law;

iv. Require any of its subcontractors or agents that receive or have access to the LDS to agree to the same restrictions and conditions on the use and/or disclosure of the LDS that apply to under this Agreement; and

v. Not use the information in the LDS to identify or contact the individuals who are data subjects.

b. The Data Recipient will limit the use or receipt of the LDS to the following individuals: BIDMC's evaluation team and Data Recipient's evaluation leads, evaluation managers, program biostatisticians.

3. **Permitted Uses and Disclosures of the LDS.** Data Recipient may use the LDS for evaluation of the Covered Entity's project-specific evaluation and overarching Community-based Health Initiative evaluation. The LDS will be used for activities outlined below.

a. Answer all impact and implementation evaluation questions outlined in the Data Recipient's evaluation plan. Covered Entity's will be responsible for answering all program-specific impact and implementation evaluation questions outlined in their evaluation plan.

b. Upon approval from BIDMC, the Data Recipient may disclose summary information derived from its analysis of the LDS for evaluation reports.

c. It is the expectation of BIDMC that CHI findings be shared in reports to stakeholders and the public.

d. All evaluation-related reports and publications based on the required core outcomes in the LDS are required to be reviewed by BIDMC prior to release.

e. If it is the Covered Entity's desire to publish findings of required core outcomes, further discussions will take place to determine roles, responsibilities, and authorship of the Data Recipient staff. Further discussions will also take place to determine roles, responsibilities, and authorship for any publications based on the LDS initiated by the Data Recipient or by BIDMC. Reasonable and ordinary standards for authorship will be applied based on the material involvement of each party in the development of publications.

f. Data Recipient will provide proper acknowledgement and reference for data provided by the Covered Entity. It is expected that the Covered Entity will reciprocate when presenting any study findings.

4. **Conditions for Use of LDS.**
   a. Data Recipient will share LDS with BIDMC.

   b. Data Recipient will not release the LDS to any third party other than BIDMC unless it receives written permission from the Covered Entity prior to sharing information.

5. **Confidentiality and Security.**
   a. Data provided by the Covered Entity and/or collected by the Data Recipient (e.g., focus group, key informant interview, staff surveys, etc.) will be raw patient level, and de-identified. Results and findings disseminated for public audiences will be aggregated.

   b. Data provided to the Data Recipient will be stored on a password protected and encrypted network. Data stored on portable devices will be required to also be password protected and encrypted.

   c. Data provided to BIDMC and accessed via its devices will be required to be password protected and encrypted.

   d. The Data Recipient and BIDMC will be allowed to store these provided data for at least five years past the life of the Covered Entity's Grant Agreement with BIDMC.

6. **Terms and Termination.**
   a. ***Term.*** The term of this Agreement shall commence as of **[INSERT DATE]** and shall continue for as long as the Data Recipient retains the LDS, unless it is terminated sooner as set forth in this Agreement.

   b. ***Termination by Data Recipient.*** The Data Recipient may terminate this Agreement at any time by notifying the Covered Entity and returning or destroying the LDS.

c. ***For breach.*** The Data Recipient shall provide written notice to the Covered Entity within ten (10) days of any alleged determination that Covered Entity has breached a material term of this Agreement. Both parties shall afford an opportunity to initiate a solution upon mutually agreeable terms. Failure to agree on mutually agreeable terms for a solution within thirty (30) days shall be grounds for the immediate termination of this Agreement by the Data Recipient.

7. **Limited Data Set Data Elements.** A LDS is defined as all impact, implementation and enrollment data for all participants recruited into the Covered Entity's [**NAME OF PROGRAM**]. Construction of the LDS will use a consistent system to create unique research identification numbers for each individual, allowing the Data Recipient to link all files for a given patient across different file types and/or longitudinally.

Specific Data Elements Requested (this list is subject to change based on project modifications or addition of project measures. Any changes will be agreed to in writing between the parties.):

- **Unique research identification number for each individual**

- **Dates of each point of data collection (e.g., baseline, follow-up, endpoint)**

- **Required implementation measures**
  - Number of staff hired
  - Number of staff/volunteers trained
  - For individual participants: date(s) of service(s) provided; type of service provided
  - Additional measures as agreed upon in the overarching evaluation planning period

- **Required participant sociodemographic characteristics**
  - Priority Neighborhood Affiliation
  - Home Zip Code
  - Race
  - Ethnicity
  - Primary Language
  - Non-/U.S. born OR Length of time in U.S.
  - Age
  - Gender Identity
  - Sexual Orientation
  - History of Incarceration
  - At least one of the following: Current household/family income AND size; Education level; Current Employment Status; and/or Current Enrollment in Benefits Programs
  - Additional measures as agreed upon in the overarching evaluation planning period

- **Required outcome measures**
  - To be defined in an addendum to this agreement

- **Aggregate program-specific data**
  - To be defined in individual program evaluation plan

8. **Timeline for Limited Data Set Submission.** The below timeline is based on the Covered Entity's Grant Agreement with BIDMC. In the event the Covered Entity's contract timeframe is amended or extended, the timeline below will be revised to align with the data collection requirements outlined in the Covered Entity's Evaluation Plan.

Limited Data Set (LDS) Quarters	Deadline for Submission
LDS 1: April 1, 2024-June 30, 2024	July 22, 2024
LDS 2: July 1, 2024-September 30, 2024	October 21, 2024
LDS 3: October 1, 2024- December 31, 2024	January 20, 2025
LDS 4: January 1, 2025-March 31, 2025	April 20, 2025
LDS 5: April 1, 2025-June 30, 2025	July 20, 2025
LDS 6: July 1, 2025-September 30, 2025	October 20, 2025
LDS 7: October 1, 2025- December 31, 2025	January 20, 2026
LDS 8: January 1, 2026-March 31, 2026	April 20, 2026
LDS 9: April 1, 2026-June 30, 2026	July 20, 2026
LDS 10: July 1, 2026-September 30, 2026	October 20, 2026

9. **Miscellaneous.**
   a. ***Change in Law.*** The parties agree to negotiate in good faith to amend this Agreement to conform with changes in federal law that materially alter either or both parties' obligations under this Agreement. Provided however, that if the parties are unable to agree to mutually acceptable amendment(s) by the compliance date of the change in applicable law or regulations, either party may terminate this Agreement as provided in section 5.

   b. ***Construction of Terms.*** The terms of this Agreement shall be construed to give effect to applicable federal interpretative guidance regarding the HIPAA Regulations.

   c. ***No Third Party Beneficiaries.*** Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

   d. ***Counterparts.*** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

   e. ***Headings.*** The headings and other captions in this Agreement are for convenience and reference only and shall not be used in interpreting, construing or enforcing any of the provisions of this Agreement.

   f. ***Amendments.*** This Agreement constitutes the entire agreement between the parties and supersedes all prior agreements and understandings, whether written or oral, relating to the subject matter of this Agreement. It may be amended only by a written instrument signed by both Data Recipient and Covered Entity.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

[GRANTEE ORGANIZATION NAME]

By:

Printed name:

Title:

Date:

Health Resources in Action, Inc.

By:

Printed name: Steven Ridini, Ed.D.

Title: President

Date: